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A bi-county examination of child welfare workers' levels of compassion fatigue and coping skills

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A BI-COUNTY EXAMINATION OF CHILD WELFARE WORKERS' LEVELS OF COMPASSION FATIGUE AND COPING SKILLS

A Project

Presented to the

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Master of Social Work

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ABSTRACT

Child welfare workers have been identified by researchers as a population of helping professionals that are vulnerable to the phenomenon of compassion fatigue. Compassion fatigue was defined for the present study as social workers' lack of feeling empathy or an inability of workers to express empathy toward clients. It was thought that the coping skills employed by child welfare workers inside and outside of the workplace contributed to the degree to which workers experience compassion fatigue. A relationship between empathy and coping was thought to exist. This study utilized a quantitative research design that gathered data through the use of an author created compassion fatigue instrument that included an Empathy scale and a Coping Skills scale. The instrument was distributed to child welfare workers in San Bernardino County and San Diego County which provided bi-county data. Results of the study revealed a significant relationship between empathy and coping. It was thought that the similarities within bi-county data allowed results to generalize to the broader population of public child welfare agencies. Recommendations for future research were made.

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We would like to thank Dr. Rosemary McCaslin for her moral support, patience, sense of humor, and multiple advisory sessions that facilitated this project. In addition, we would like to thank Sally Richter at the San Bernardino Department of Children's Services for providing a link to the agency, assisting with data collection, and for listening. Also appreciated was Frankie Scarlett for assistance distributing questionnaires in Oceanside. It has been a pleasure working with these three professionals.

DEDICATION

This project is the result of the sacrifices made by two husbands who were willing to do whatever it took to make this research study happen. Thank you Denis Gusakov and Kenny Keyes; we love you.

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CHAPTER ONE

INTRODUCTION

Problem Statement

The prevalence of child maltreatment in the United States has presented a number of challenges to social workers within Child Protective Services agencies. The United States Department of Health and Human Services, Children's Bureau reported in 1996 that three million children were reported to Child Protective Services agencies for investigation of maltreatment, with approximately one million substantiated cases (National Association of Counsel for Children, n.d.).

In an attempt to aid abused children and to provide for minor's safety and well-being, social workers often find themselves in harsh and overwhelming situations. The rising numbers of reported cases of abuse, combined with large caseloads, leaves little time for social workers to process the traumas witnessed. A study by the Children's Aid Society of Toronto (Howe & McDonald, 2001) found that 82.7 percent of child welfare workers have reported being exposed to a traumatic event related to the job, and that 70 percent of those resulted in emotional trauma experienced by the worker. Types of traumas reported by

Howe and McDonald (2001) were assault, threats of assault, and child death. Exposure to consistently elevated levels of crisis requiring workers to express high levels of empathy toward clients can result in workers' experiencing symptoms such as depression, irritability, apathy, lack of concentration, and fatigue, ultimately leading to burnout. These symptoms resulting from work in the helping professions have been acknowledged as a phenomenon called compassion fatigue (Figley, 1995).

Compassion fatigue, while common among helping professionals has been noted as especially prevalent among child welfare workers (Anderson, 2000; Figley, 1995). The weight of the emotional trauma that the workers experience combined with high caseloads (Child Welfare League of America, 2004) and soaring turnover rates all contribute to the intensity of the workers' stress and potential for compassion fatigue.

Compassion fatigue has been described as a detrimental phenomenon in the child welfare field because of its consequences to the clients that are served. High turnover rates of child welfare workers, due to compassion fatigue can affect the therapeutic relationship that the worker and the client have established. Once a worker has resigned, the client's relationship with the agency is

likely to be disrupted. Since most Child Protective Services clients are court ordered to work with the agency, the client is forced to start the whole process again with a new worker, which has presented many Child Protective Services clients with a negative experience.

Turnover rates of Child Protective Services workers have been identified by the Child Welfare League of America (2004) as 45% for caseworkers in private agencies, and 20% for direct service staff in public agencies. Social worker retention has been recognized as a factor that can lead to work overload on the workers that are left at the agency. Costs to the agencies also increase when money is spent to train the constant flow of new employees (Anderson, 2000). At times the rapid turnover rate of child welfare workers has lead to the hiring of less competent and educated workers, severely lowering the agency's capacity to provide proficient services to clients. It has been reported that a "crisis" exists in child welfare, and that the agencies expected to handle some of society's most serious problems are "understaffed, undertrained, and undervalued" (Child Welfare League of America, 2004).

Although this issue has been identified within child welfare agencies across the United States, it has been one

of the most ignored and overlooked. In order for agencies to identify and begin to make the policy changes needed to contain this widespread epidemic so prevalent in child welfare practice, further research is required. The fact that child protection agencies are driven by a complex system of legal mandates, policies and financial constraints has made the need for education and awareness of compassion fatigue even more crucial to the survival of these agencies and their workers. Although there are no polices currently in place that address this issue, the need is rapidly growing due to the complexities of child welfare practice. As budget cuts continue to be on the rise, intervention aimed at prevention will be required by policy makers to reduce worker turnover. It is anticipated that as Child Protective Services agencies strive to meet the needs of their social workers, these same workers will be better equipped to meet the increasing demands for services.

Purpose of the Study

The purpose of this study was to compare and contrast two closely located counties and their social workers' levels of compassion fatigue in relation to their coping skills in the arena of Child Protective Services. This

study identified levels of compassion fatigue among child welfare workers. Implicit county policy such as time off from work, education about compassion fatigue and coping strategies, and workers' level of education was examined in relation to compassion fatigue. A relationship between the ways in which workers cope with the trauma of their job and levels of compassion fatigue was expected.

The majority of clients seen by Child Protective Services workers are considered involuntary clients who represent a unique and often difficult population, since many of these clients have been identified as resistant to intervention. Clients are typically ordered by the Juvenile Dependency Court to receive case management services and interventions from the worker. The adversarial nature of the court system has lead to clients blaming the social worker for their problems with the child welfare system, thus leading to anger at the worker. Blame for the problems experienced by families can create even greater levels of stress and frustration for workers who may have already had difficulties coping already.

By conducting a bi-county examination of compassion fatigue and coping strategies for workers within San Bernardino and San Diego Counties, specific differences and similarities that exist between the two counties and

their child welfare workers were revealed. Levels of compassion fatigue for child welfare workers were analyzed and compared between the two agencies. In addition, how child welfare workers cope with compassion fatigue, as well as differences between education provided by the two counties for workers regarding compassion fatigue and coping strategies were studied as well.

This study dissected the apparent dilemma through the use of a quantitative research design. It was thought that the most efficient method of acquiring the information needed for this study was to utilize questionnaires. Questionnaires, rather than interviews gave the participants privacy when answering questions that workers may have perceived as personal, and enabled these workers to be as honest as possible in their responses. It was thought that workers' anonymity would be further protected and that they would feel more comfortable since face to face interviews were not conducted. It was also thought that, since child welfare workers are overloaded with many other tasks, use of a questionnaire would be less time consuming for workers, leading to greater levels of participation and ultimately, a larger sample for the study. The questionnaires were distributed to the county

child welfare worker participants by the researchers in each of the individual counties' environments.

Significance of the Project for Social Work

High turnover among social workers, inefficiency in job performance, apathy in working with clients, and possible harm to clients were all reasons why this study was needed. The results of this study brought to light differences between the ways in which the two counties deal with the phenomenon of compassion fatigue in their workers. In addition, child welfare workers' coping strategies were analyzed and compared between the counties. Finally, the results of this study demonstrated the need for specific policy change specifically directed toward social worker retention in Child Protective Services.

Compassion fatigue in social workers has been observed as affecting social work practice at every stage of the generalist intervention process, including engagement, assessment, planning, implementation, evaluation, termination, and follow-up (Kirst-Ashman & Hull, 2002). The symptoms of compassion fatigue included, but were not limited to apathy, fatigue, and burnout, which inhibit social workers' ability to engage clients

and build rapport. Social workers who have experienced compassion fatigue have been identified as having difficulty assessing clients and viewing them in a more negative light, rather than assessing for strengths. Clients working with social workers who have exhibited high levels of compassion fatigue have at times been subjected to complicated case plans that set the client up for failure. Social workers suffering from compassion fatigue could also terminate client relationships prematurely, and fail to follow-up with clients. Overall, compassion fatigue as identified in child welfare workers was thought to pose a serious risk to client, and specifically child safety.

The study established relevance to child welfare practice by suggesting ways to improve training and preparation for social workers to help them deal with the difficulties associated with child protection. By gaining insight into the phenomenon of compassion fatigue and child welfare workers' coping strategies across the two counties, the current study was thought to raise awareness of the problem in the field and was expected to inspire further research and support for workers to allow them to provide for the best interests of children and families. The results of the study were expected to demonstrate the

importance and urgency of education about compassion fatigue among child welfare staff in order to lower the high turnover rates experienced by Child Protective Services agencies. It was thought that as compassion fatigue as related to child welfare workers was explored, effective ways of training and maintaining these workers in child welfare agencies would be revealed, thus improving the quality of service to children and families.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Compassion fatigue has been thought to result from the emotional nature of work in the helping professions, especially in child protection. The challenges experienced by child welfare workers in the field and the stressors associated with working in child welfare were examined in the following chapter. Similarities have been identified as existing between the phenomenon of burnout and compassion fatigue. Since burnout has been identified as a potential consequence of compassion fatigue, leading to the high turnover rates of child welfare workers, the concept of burnout and how workers cope with burnout was examined. Finally, compassion fatigue was defined and the theoretical perspectives related to the development and management of compassion fatigue were reviewed.

Challenges and Stressors for Child Welfare Workers

Most individuals entering the field of child protection do so with the intention of being of service and help to others. However, this calling to work with children and families in the capacity of child welfare

requires workers to not only witness children living in deplorable conditions, subjected to abuse and neglect, but also to intervene on behalf of families concerning the multiple factors that contribute to child maltreatment (Dane, 2000; Um & Harrison, 1998). These factors include, but are not limited to parents' own history of abuse, socioeconomic status, family structure, parent's gender, and substance abuse issues (Um & Harrison, 1998). In addition to witnessing the results of neglect and violence toward children, workers often listen to parents and children recount the traumatic events that have brought them to child Protective Services Agencies (Anderson, 2000). Researchers have acknowledged that continued exposure to the pain of others puts social workers at risk for developing compassion fatigue (Anderson, 2000; Sabin-Farrell & Turpin, 2003)

In order to handle the numerous issues presented within a single case, workers are trained to take a family-centered approach to child welfare practice (Pecora, Whittaker, Maluccio, & Barth, 2000; Walton, Sandau-Beckler, & Mannes, 2001). This requires workers to simultaneously emphasize child safety first and foremost, while providing services for family reunification when out of home placements have been utilized, in addition to

planning for children's placement in a permanent home when reunification fails (Pecora et al., 2000; Walton et al., 2001). To accomplish this, child welfare workers take on various roles on behalf of clients, such as advocate, counselor, educator and more, all while navigating an ever changing legal system (Dane, 2000).

The Concept of Burnout in Child Welfare

The organizational literature has recognized the concept of burnout among employees experiencing job stress for several decades (Halbesleben & Buckley, 2004). According to Halbesleben and Buckley (2004), Maslach (1982) conceptualized burnout as emotional exhaustion, depersonalization, and personal accomplishment in formulating the Maslach Burnout Inventory. Emotional exhaustion has been identified as leaving a worker feeling as though they do not have any more of themselves to give to the job, while depersonalization has been identified as a form of indifference or an inability to care about the job, and personal accomplishment has been related to an individual's perception of their work performance (Halbesleben & Buckley, 2004). The Maslach Burnout Inventory has been noted throughout the burnout literature

as the dominant measure used (Halbesleben & Buckley, 2004).

In their review of the burnout literature, Halbesleben and Buckley (2004) pointed to the conservation of resources model (Hobfoll, 1989) as an explanation for burnout. This model has predicted burnout when employees believe there is the potential for loss of something significant to them on the job (Halbesleben & Buckley, 2004). The threat of loss can pertain to resources gained from the job or resources important to the job, as well as a worker putting energies into the job without seeing results (Halbesleben & Buckley, 2004). Since child welfare workers often lack sufficient resources to help their clients to begin with, this model has been used to explain burnout for this profession (Anderson, 2000).

Anderson's (2000) research involving burnout and coping strategies among "veteran" child welfare workers has confirmed that child welfare workers are more likely to have a higher risk of burnout than social workers working outside child welfare. The study examined 121 child welfare workers who provided direct service to clients and 30 supervisors from the southeastern United States. Workers were classified as "veterans" if they had worked in child welfare 2 years or more (Anderson, 2000).

Participants were recruited from a pool of workers who attended a workshop on "surviving" and "thriving" in Child Protective Services (Anderson, 2000).

Of interest to the study was how child welfare workers cope with the stress of the job and the impact of their coping strategies on burnout (Anderson, 2000). Coping strategies were defined as engaged, which included techniques for coping such as problem-solving, expressing emotion, cognitive-restructuring, and seeking social support. Disengaged coping on the other hand was characterized by the author as individuals avoiding the problem and becoming socially withdrawn, in addition to behaviors such as wishful thinking and self-criticism (Anderson, 2000). Results showed that workers were more likely to use engaged coping rather than disengaged coping. However, workers in the study reported using problem-solving and cognitive-restructuring more often than seeking social support and expressing their emotions (Anderson, 2000).

Burnout has been recognized as a phenomenon that is present across various types of organizations and is not limited to the social services or helping professions. The fact that compassion fatigue has been identified as a response of those in the helping professions that are

directly or indirectly exposed to the traumatic experiences of others has made it of interest to the study. The ways child welfare workers cope with burnout has also shed some insight into effective coping for compassion fatigue.

Compassion Fatigue

Helping professionals, specifically child welfare workers have been identified as vulnerable to compassion fatigue (Anderson, 2000; Figley, 1995; Sabin-Farrell & Turpin, 2003). Compassion fatigue has alternately been referred to in the literature as vicarious trauma or vicarious traumatization, secondary vicarious trauma, and by some as burnout (Sabin-Farrell & Turpin, 2003). However, for the purposes of the study, compassion fatigue was differentiated from burnout due to the fact that compassion fatigue primarily affects those who witness, listen to, or are affected in some way by the traumatic experiences of others, whereas burnout appears to arise from work strain and emotional exhaustion.

It has been acknowledged that professionals such as police officers, emergency room staff, nurses, firefighters, attorneys, and journalists are often affected by compassion fatigue. However child welfare

workers carry the additional burden of knowing a child may be harmed or killed due to a decision they make related to a child's placement or removal from a home, leaving child welfare workers even more vulnerable to compassion fatigue (Sabin-Farrell & Turpin, 2003). Workers who exhibited high levels of empathy toward clients and their life circumstances also appeared to be at the greatest risk of compassion fatigue, and individuals who have experienced a similar trauma to the one being recounted are more likely to express symptoms (Anderson, 2000; Figley, 1995).

Of concern to researchers and supervisors in the field has been the development of Post Traumatic Stress Disorder (PTSD) among child welfare workers when compassion fatigue or vicarious trauma has gone without intervention (Regehr, Hemsworth, Leslie, Howe, & Chau, 2004). Regehr et al. (2004) distributed 175 questionnaires to workers with the Children's Aid Society of Toronto. The researchers stated that they chose this population of three million people, largely children and families, because the agency had experienced two fairly recent child death investigations near the time of the study (Regehr et al., 2004). Burnout related to organizational stress, and secondary trauma due to direct work with clients was analyzed to predict rates of PTSD (Regehr et al., 2004).

It was found that individuals who reported having strong interpersonal relationships reported less distress, and those with less frequent and less recent exposure to trauma also reported less distress (Regehr et al., 2004). Interestingly, those who reported the highest levels of symptoms resulting from trauma also reported the most personal growth (Regehr et al., 2004). Individual worker's resilience was given as an explanation for growth in response to trauma (Regehr et al., 2004).

Consequences of compassion fatigue for child welfare workers and child welfare agencies have made understanding effective coping for this phenomenon imperative. A model for working with child welfare workers and secondary trauma was developed by Dane (2000) out of her work with focus groups. In 1997, two focus groups were conducted to answer questions such as "what was it like for you when you first started working with abuse and neglect of children," and "what experiences did you have growing up that may have prepared you for this work with children and families" (Dane, 2000, p. 4). Participants were also asked to describe cases involving trauma to a child, and how the worker coped with stress (Dane, 2000).

Results obtained from the focus groups were used by the author to develop a two-day training curriculum called

"Stress Inoculation Training: Reducing Secondary Psychological Trauma of Child Welfare Workers" (Dane, 2000, p. 1). Although the initial study from which the curriculum was formulated was not evaluated for effectiveness in reducing effects of secondary trauma for child welfare workers, the author stated that awareness among workers of secondary trauma was a positive initial outcome (Dane, 2000). In addition Dane (2000) recommended training for supervisors on the effects of secondary trauma on their workers.

The overlap of terms used to describe compassion fatigue made teasing out the literature specific to compassion fatigue difficult. However, this was also construed to mean that more research specific to compassion fatigue was necessary to validate social workers' experience of trauma in the field. Since the body of research on compassion fatigue appeared to point to the inevitability of child welfare workers experiencing compassion fatigue at some point in their careers, it was thought to be of value to continue to explore the coping strategies that enable workers to manage the effects of the symptoms when they crop up.

Theories Guiding Conceptualization

How child welfare workers experience and cope with compassion fatigue can be readily explained in the context of systems theory. A system can consist of individuals, groups, and organizations that are interacting with one another and are subject to change (Kirst-Ashman & Hull, 2002). When examining the traumatized client and social worker in terms of systems theory, the two systems can be observed as influencing one another through input and output (Kirst-Ashman & Hull, 2002). Although the social worker provides intervention for the client system, the impact of the observed trauma has been identified to influence and change the social worker as well (Dane, 2000). For example, a worker who has not seen much change when providing intervention to the client system may experience lowered self-esteem, or feelings of hopelessness (Dane, 2000). When out of balance in this way, the worker will attempt to return to homeostasis or equilibrium, which is typical of a system out of balance (Kirst-Ashman & Hull, 2002).

Crisis theory has also helped explain compassion fatigue among social workers. A crisis has been defined by experts as an individual's perception of a stressful situation or event that jeopardizes a person's ability to

cope (Roberts, 2000). The event that precipitates a crisis can be a critical incident or the result of a number of stressful events, which results in a cumulative effect (Roberts, 2000). While a critical incident, such as a child death can result in compassion fatigue or a crisis for a social worker, typically, compassion fatigue occurs in response to repeated exposure to client's trauma (Anderson, 2000).

Another explanation for the development of compassion fatigue has been found in psychodynamic theory. Countertransference, has been identified as a conscious or subconscious reaction of the social worker or therapist to the client or client's issues, which has been noted in the psychodynamic literature (Figley, 1995). As stated in Figley (1995, p. 9), "Corey (1991) defined countertransference as the process of seeing oneself in the client, of overidentifying with the client, or of meeting needs through the client." Based on psychodynamic theory and the model of countertransference presented, how countertransference is handled by the social worker may contribute to the development of compassion fatigue. This theory has also been of interest to the study, due to the aspect of coping related to managing countertransference.

Finally, child welfare workers are confronted with the grief and loss of children and families on a consistent basis. Children who are removed from their family homes, and are placed into foster care experience the loss of parents, familiar surroundings, and sometimes even siblings when they are unable to be placed in the same foster home. When children in foster care experience disrupted placements, they experience loss all over again. Parents, whose children are removed from the home for abuse or neglect, grieve over the loss of their children to the child welfare system. Social workers who observe these multiple losses and the grief of their clients are considered vulnerable to compassion fatigue, due to the vicarious exposure to clients' trauma (Digiulio, 1995).

Summary

Child welfare workers are widely recognized among social work researchers and professionals as workers who consistently face high levels of stress. The occurrence of compassion fatigue as it has been described in this chapter is important to consider when examining child welfare practice. In a job that presents many hazards to begin with, in addition to multiple client needs and a complex legal system, it is crucial that agencies take

every precaution to preserve child welfare workers emotional health. The study clarified how compassion fatigue is experienced by workers in these agencies and revealed effective coping for those affected by it.

CHAPTER THREE

METHODS

Introduction

This chapter will cover the design of the study, the research sample, methods of data collection and the instruments used. Procedures for how data were gathered, recruitment of participants, and the protection of human subjects will be explained. In addition, an overview of the research method will be provided, including data analysis, sample size and selection criteria, independent and dependent variables, levels of measurement, and the quantitative procedures used.

Study Design

The purpose of the study was to explore the correlation between Child Protective Services social workers' levels of compassion fatigue and their coping strategies. An author created questionnaire (Appendix A) was used to conduct quantitative research. The use of a questionnaire with a six-point Likert scale allowed for the use of statistical analysis of the data and inferences from the results. This method of data collection was also chosen due to the highly personal nature of the information participants provided. It was thought that the

use of a questionnaire permitted participants to make a self-report of their experiences and ways of coping that protected their anonymity.

Authors of the study, graduate students in the Master of Social Work program at California State University, San Bernardino have concluded that the bi-county aspect of the research design obtained a broader population of child welfare workers for the sample. Results of the bi-county sample were expected to generalize to child welfare workers in other counties. To study this unique population of social workers an author created questionnaire (Appendix A) was used. The use of a newly created instrument showed the potential for strengths and weaknesses. An instrument designed specifically for the study of child welfare workers allowed the researchers to tease out issues relevant to child welfare practice. However, reliability and validity of the instrument were unknown, due to lack of prior use.

The present study examined how child welfare workers' coping strategies affected levels of compassion fatigue. Compassion fatigue was operationally defined as workers' inability to feel and express empathy toward clients. Social workers, who reported actively seeking out positive coping strategies such as physical activity and social

support, were expected to score higher on the Coping scale than those who withdrew from others and remained inactive (Anderson, 2000).

It was thought that workers who demonstrated higher levels of coping would exhibit lower levels of compassion fatigue. Workers with lower levels of coping on the other hand were expected to express higher levels of compassion fatigue. A relationship between compassion fatigue and coping skills was expected to exist. Other factors of interest to the study were workers' area of specialization, number of years in CPS, number of years with current agency, time off from work, and exposure to compassion fatigue training.

Sampling

Child Protective Services social workers from San Bernardino and San Diego Counties were sampled. Criteria for the sample were workers' specialization in emergency response/intake, adoptions/permanency planning, family maintenance, or family reunification. The sample demonstrated the diverse nature of social workers in areas such as gender, ethnicity, level of education, and length of time with the county.

Within each of the two counties, workers were sampled from the two agencies' various offices. The researchers recruited participants from the offices of Oceanside and Escondido within San Diego County. Participants were also recruited from the two San Bernardino City offices, in addition to the Barstow, Rancho Cucamonga, Victorville, and Yucca Valley offices within San Bernardino County. These particular locations were chosen due to the researchers' access to them. The Oceanside, Rancho Cucamonga, and San Bernardino City offices represented social workers from urban areas, while the Escondido, Barstow, Yucca Valley, and Victorville locations provided access to workers in rural settings. Seventy-seven participants were recruited from San Bernardino County, and fifty participants were recruited from San Diego County.

Convenience selection was used to recruit participants. Questionnaires were distributed and returned through the inter-office mail system in San Bernardino County. San Diego County questionnaires were placed in individual social worker's mail boxes and returned to the researcher in a box centrally located for participant convenience. Participants were compensated for their participation with the opportunity to enter a raffle for

two twenty-five dollar gift cards to Target and two twenty-five dollar gift cards to Claim Jumper.

The two counties were selected for the study due to the researchers' ability to have access to both agencies. As Master of Social Work students, the researchers participated in an internship program within each county, which provided the researchers with the ability to recruit and collect data from participants in a timely manner. In addition, San Bernardino and San Diego Counties' Child Protective Services agencies both have a large pool of child welfare workers from which the researchers were able to recruit participants. The workers in these agencies were valuable to the study due their direct contact with clients and their vulnerability to compassion fatigue. Permission from both agencies was obtained before any questionnaires were distributed. The research went through a Human Subjects Review process at both agencies and the university.

Data Collection and Instruments

Data were collected on child welfare workers' levels of compassion fatigue and levels of coping. An author created instrument (Appendix A) was used for this study because of the need for a questionnaire designed to

investigate compassion fatigue and coping that was directed specifically to child welfare workers. Statements for the compassion fatigue scale were conceptualized from the research on compassion fatigue indicating a reduced capacity for empathy (Sabin-Farrell & Turpin, 2003). The coping statements were intended to reflect the differences in active coping, where one seeks out relief of symptoms, as compared to avoidant patterns of coping as evidenced by withdrawal.

For the study, compassion fatigue was operationally defined as to whether or not workers were able to feel and respond with empathy toward clients. A relationship was expected between compassion fatigue and coping skills. The dependent variable was identified as level of compassion fatigue and the independent variable was identified as social workers' level of coping skills.

Dependent and independent variables were measured at the interval level, and their measurement was based on participant's response to a six-point Likert scale for each item (1 = Strongly Disagree, 2 = Disagree, 3 = Disagree Somewhat, 4 = Agree Somewhat, 5 = Agree, and 6 = Strongly Agree). The way in which the Likert scale was scored (1 - 6) allowed the researchers to group participant responses from low to high on empathy and

coping skills based on total scores. The questions addressing empathy within the compassion fatigue questionnaire consisted of 15 items with total scores ranging from 15 (low) to 90 (high). Likewise the 23 items in the Coping scale had a range of scores from 23 (low) to 138 (high). It was concluded that those who scored higher on coping reported more active coping strategies, while those who scored low for coping reported more passive coping (Anderson, 2000).

Sample items for the Empathy scale within the compassion fatigue questionnaire included statements such as, "I am numb to the issues surrounding child abuse and neglect and find it difficult to express compassion toward maltreating parents," and "It is important to me to respond empathically toward clients and their situations." Statements for empathy were conceptualized from the research on compassion fatigue that indicated a reduced capacity for empathy (Sabin-Farrell & Turpin, 2003). Items for the Coping scale included statements such as, "I cope with the stress of exposure to other's traumatic experiences by seeking support in supervision," and "When I feel stressed-out from working with clients, I tend to self-medicate with food, alcohol, or drugs." Theories of coping dimensions such as problem solving, seeking social

support, expressing emotions, problem avoidance, and social withdrawal were included (Anderson, 2000).

The following demographic variables were included; age reported at last birthday, gender, ethnicity, number of years in child welfare, number of years with the current County, level of education, area of specialization, job title, income level, average work hours per week, amount of vacation time within the last year, and county sponsored training on compassion fatigue and coping. Demographic variables for number of years in child welfare, number of years employed with current County, average work hours per week, amount of vacation time within the last year and age, which was reported at last birthday were measured at the interval level. Level of education and income level were measured at the ordinal level, and gender, ethnicity, area of specialization, and title were measured at the nominal level. Demographic information was collected at the end of the questionnaire.

The fact that the instrument was designed to specifically reflect the uniqueness of the population of child welfare workers was considered a strength for the study. A limitation considered was the instrument's lack of previous use in other studies which could have prevented the authors from recognizing weaknesses in

design of the questionnaire. In addition, replication was limited due to the specialized nature of the instrument.

The instrument was assessed for face validity through instrument pre-testing. This was accomplished by distributing the questionnaire to twenty-two Master of Social Work students specializing in child welfare, within current internships with Child Protective Services in San Bernardino, Los Angeles, and Orange Counties. The Master level students reviewed the individual items within the questionnaire to assess the readability and understandability of the items.

It was suggested by the Master level students that the researchers use agency acronyms specific to the individual agencies within the questionnaire to avoid any confusion among participants. Due to this suggestion, the researchers used two versions of the questionnaire. This difference is seen in the agency acronym DCS (Department of Children's Services) for San Bernardino, and HHSA (Health and Human Services Agency) for San Diego. This weakness in the instrument was identified and the questionnaire was revised prior to its use in the study. Both versions of the questionnaire are located in Appendix A.

Reliability was analyzed for the questionnaire by computing the coefficient alpha for the Empathy scale and the Coping scale. Through the use of factor analysis three subscales were distinguished within the Empathy scale and two subscales were distinguished within the Coping scale. Subscales within the Empathy scale were identified as Empathy toward Clients, Responding with Empathy, and Lack of Empathic Feelings. The two subscales within the Coping scale were identified as Exercise and Self-Care, and Supportive Relationships.

Procedures

One researcher distributed and collected the questionnaires (Appendix A) at the Department of Children's Services San Bernardino County through the inner-office mail system. Questionnaires were hand delivered to participants at the Department of Children's Services San Diego County by the other researcher. Participants in San Diego County were instructed to place completed questionnaires in a box provided for their convenience when they were finished. Participation was done on an individual basis, and completion of the questionnaire took approximately twenty minutes. A raffle for four twenty-five dollar gift cards was offered as

compensation for participation. Two gift cards were purchased at Claim Jumper Restaurant, and two gift cards were purchased at Target.

Protection of Human Subjects

Individual child welfare workers were surveyed through the use of a questionnaire for the study. Participation in the study was voluntary and no identifying information was asked from the participants on the questionnaire. Informed consent was provided to the participants (Appendix B) and participants marked the appropriate space agreeing to consent to participate with an X.

An application to the Department of Social Work Sub-Committee of the Institutional Review Board (IRB) at California State University San Bernardino was made for the study, and approval was gained prior to any contact with participants. Included in the application packet for IRB approval was the questionnaire (Appendix A), informed consent (Appendix B), and debriefing statement (Appendix C) that was provided to participants. To further protect the rights of participants, agency Human Subjects Review approval was obtained.

Data Analysis

Seventy-seven participants were recruited for the study from San Bernardino County, and fifty participants were recruited from San Diego County. Quantitative data were extracted from the participants' responses to the author created compassion fatigue questionnaire. Data analyzed were used to determine whether or not a relationship could be established between compassion fatigue, which was defined by social workers' responses to the Empathy scale and Coping skills scale. A comparison of county data was performed as well.

The mean, median, and mode, or measures of central tendency, as well as standard deviation were computed for the independent and dependent variables, and for demographic data. To examine the relationship between the independent variable coping skills and the dependent variable compassion fatigue, correlations were conducted for the empathy and coping scales, and subscales. In addition, *t*-tests and one-way analysis of variance (ANOVA) were used to compare the means of the Empathy and Coping scales, subscales, and demographic variables. These statistical measures were used to describe the research sample, answer the research question, and provide insight into the phenomenon of compassion fatigue.

Summary

This chapter explored the methods of the study including the purpose of the study, and the quantitative study design. The population of child welfare workers to be sampled, data collection methods and the instrument used were all evaluated. A thorough examination of the procedures, protection of human subjects, and data analysis was conducted.

CHAPTER FOUR

RESULTS

Introduction

The following chapter will discuss how the data were analyzed and will present the results of the quantitative procedures that answered the research question. Descriptive statistics will be used to detail the demographic data provided by participants. County data will also be presented.

Presentation of the Findings

The study analyzed levels of compassion fatigue and coping skills of child welfare workers in two Southern California Counties. It was of interest to the study to determine whether or not workers who demonstrated higher levels of coping would exhibit lower levels of compassion fatigue. Workers with lower levels of coping on the other hand were expected to express higher levels of compassion fatigue. A relationship between the dependent variable compassion fatigue and the independent variable coping skills was expected to exist. Demographic variables important to the study were social workers' area of specialization, number of years in child welfare, number

of years with current agency, time off from work, and exposure to compassion fatigue training.

One hundred and twenty seven participants were recruited from San Bernardino County (n = 77) and San Diego County (n = 50). Of the participants in the data set, more females (n = 99) were represented than males (n = 28), and ethnicity was reported as African American (n = 20), Caucasian (n = 77), Hispanic (n = 20), Asian (n = 4), and other (n = 5). Table 1 delineates participants according to gender and ethnicity.

Table 1. Gender and Ethnicity

	AA	CA	HI	AS	Other
Male	2	14	7	3	2
Female	18	63	13	1	3

Level of education reported by the sample were 25% Bachelors (n = 32), 68% Masters (n = 87), 2.3% Licensed (n = 3), and 3.9% Doctorate (n = 5).

Area of specialization for the participants within child welfare were reported as Adoptions and Permanency Planning (n = 24), Family Reunification and Family Maintenance (n = 20), Emergency Response (n = 49), and more than one specialization (n = 31). Participants

reported income as 2.3% earned under $35,000 ($n$ = 3), 8.6% earned $35,000 to $45,000 ($n$ = 11), 39.1% earned $45,000 to $55,000 ($n$ = 50), 35.9% earned $55,000 to $65,000 ($n$ = 46), and 10.9% earned over $65,000 ($n$ = 14). Title of respondents were Social Worker II (n = 11), Social Service Practitioner or Protective Service Worker II (n = 81), Protective Service Worker III (n = 9), and Supervisor or Manager (n = 7). Mean scores were computed for, number years employed in child welfare (M = 7.89, SD = 6.23), and number of years with the county (M = 7.86, SD = 5.40). Average hours in a workweek (M = 43.64, SD = 10.30), and number of vacation days within the last year (M = 14.85, SD = 12.46) were reported.

Total scores for each scale within the questionnaire were analyzed for reliability. Cronbach's Alpha was computed for the Empathy scale (Alpha = .2584) and for the Coping scale (Alpha = .1267). To explain these low levels of total scale reliability, factor analysis was conducted for each scale to evaluate for subscales and Alpha levels were assessed for each subscale.

Varimax Rotation Method revealed three subscales within the Empathy scale, including Empathy toward Clients (Alpha = -.6408), Responding with Empathy (Alpha = .7120),

and Lack of Empathic Feelings (Alpha = .5774). The subscale for Empathy toward Clients included seven items from the questionnaire (questionnaire items: 6, 8, 11, 20, 26, 30, & 31). Typical items for the Empathy toward Clients subscale included, "I am able to express empathy toward abusive parents, their children and families that I come into contact with as a DCS/HSSA worker," and "I can identify with the difficulties and challenges faced by DCS/HSSA clients, and I express compassion and empathy toward them readily."

Three items were identified within the Responding with Empathy subscale (questionnaire items: 19, 24, & 33). "I use reflective listening when communicating with clients and respond to them empathically," and "It is important to me to respond empathically toward clients and their situations" are examples of items from this subscale. The final subscale that was revealed for empathy was Lack of Empathic Feelings (questionnaire items: 4 & 17). "I am frustrated with client's excuses for not following case plans, and feel cynical about their ability to change" and "I am easily irritated and frustrated by the clients I serve at DCS/HSSA" are items in this subscale. Questionnaire items can be viewed on Appendix A.

Additionally, Varimax Rotation Method for the Coping scale detailed two subscales that included Exercise and Self-Care (Alpha = -.6752), and Supportive Relationships (Alpha = -.6324). The subscale for Exercise and Self-Care (questionnaire items: 9, 10, 29, 35, & 37) contained items such as, "I am too exhausted after work to exercise and would consider myself a 'couch potato'," and "I tend to neglect self-care, due to the high demands related to working with DCS/HSSA clients." Finally, the Supportive Relationships subscale (questionnaire items: 15, 28, & 36) contained items such as, "I cope with the stress of exposure to other's traumatic experiences by seeking support in supervision" and "I do not seek out supportive relationships with colleagues at DCS/HSSA."

Rotated Component Matrices that were used to determine subscales for empathy and coping are located in Appendix D. Average Rotated Component Matrix scores for empathy ranged from moderate to high on all three subscales. However, average Rotated Component Matrix scores for coping ranged from moderate to high for the Exercise and Self-Care scale, and average scores for the Supportive Relationships scale were low. The Key for Rotated Component Matrices is located in Appendix E, and

descriptive statistics for total scores of empathy, coping, subscales are located in Table 2.

Table 2. Descriptive Statistics for Scales and Subscales

	Empathy Scale	Coping Scale	Exercise SelfCare	Support Relat	Empathy Toward Clients	Empathic Response	Lack of Emp Feelings
Mean	54.10	79.62	16.47	10.02	25.38	14.18	5.42
Median	54.00	79.00	16.00	10.00	25.00	15.00	5.00
Mode	55.00	78.00	15.00	9.00	25.00	15.00	4.00
Minimum	44.00	67.00	8.00	5.00	21.00	8.00	2.00
Maximum	66.00	101.00	24.00	15.00	31.00	18.00	10.00

A correlation computed for the total scores of the Empathy and Coping scales determined that their correlation was significant (r = .391, p = .000). Bivariate analysis of the correlations between total scores for the Empathy and Coping scales and the number of hours worked per week, vacation days within the last year, number of years participant's employed with their present county, and number of years employed in DCS/HSSA were computed. The relationship between the number of years participants were employed in Child Protective Services and the number of years participants were employed with their present county was determined significant (r = .853, p = .000).

Regarding the previously identified subscales, a significant relationship was established between the subscales Responding with Empathy and Empathy toward Clients (r = .246, p = .004), and Lack of Empathic Feelings and Empathy toward Clients (r = .235, p = .005). In addition, a significant negative correlation was identified between Lack of Empathic Feelings and Responding with Empathy (r = -.352, p = .000). A significant negative correlation was also found for number of hours participants worked per week and Empathy toward Clients (r = -186, p = .043).

Total scores on the Empathy scale and Coping scale were compared using a t-test for the demographic variables county, gender, and training. T-tests revealed no significant results for the Empathy and Coping scales regarding demographic variables. One Way Analysis of Variance (ANOVA) was used to compare the means of the total scores on the Empathy and Coping scales regarding demographic variables specialization, education, ethnicity, title, and income. No significant differences were detected for the ANOVA statistical measures that were computed for total scores of the Empathy and Coping scales.

Subscales for empathy and coping were also analyzed for mean differences using *t*-tests and ANOVA. *T*-tests for subscales Responding with Empathy, Empathy toward Clients, Lack of Empathic Feelings, Exercise and Self-Care, and Supportive Relationships were conducted in regards to gender, training, and county. A significant difference was found for the Exercise and Self-Care subscale ($t = -2.01$, $df = 119$, $p < 0.05$) and having received training on coping strategies (Yes, $M = 16.10$; No, $M = 17.04$). Results of *t*-tests found significant differences for the Responding with Empathy scores ($t = -2.10$, $df = 119$, $p = .038$), males ($M = 13.44$) and females ($M = 14.39$). A significant difference was found for the Empathy toward Clients subscale scores ($t = -2.851$, $df = 117$, $p = .005$), San Bernardino County ($M = 25.03$) and San Diego County ($M = 25.98$).

One-Way Analysis of Variance (ANOVA) was computed for each of the subscales Empathy toward Clients, Responding with Empathy, and Lack of Empathic Feelings and income, education, ethnicity, specialization, and title. Alternately, ANOVA was used to analyze the subscales Exercise and Self-Care, and Supportive Relationships and income, education, ethnicity, specialization, and title. No significant differences were detected for Empathy and

Coping subscales using ANOVA. Multiple Regression was used to further investigate demographic variables and subscales, but did not result in significant results.

Summary

Descriptive statistics were used to present participants' demographic data. Alpha levels for the instrument's two primary scales Empathy and Coping were detailed. In addition, factor analysis was utilized to determine subscales within the Empathy and Coping scales, and alpha levels were identified for each subscale. Finally, bivariate statistics such as correlations and *t*-tests were computed to determine significant relationships and mean differences.

CHAPTER FIVE

DISCUSSION

Introduction

A discussion of the results and limitations of the study will be covered in the following chapter. How the study supports previous studies will also be presented. In addition, the way in which the study can be applied to social work practice and policy within child welfare will be explored. Recommendations for social work practice, policy, and future research regarding this topic will be made.

Discussion

Public child welfare agencies, such as the two agencies that participated in the study are faced with mounting challenges to protect children and to provide services to the parents, families, and communities of children who are abused and neglected. In the process of providing services that address the safety, well-being, and placement permanence of abused and neglected children, child welfare workers are exposed to the trauma of others on a consistent basis. In addition, those whose trauma they witness or are exposed to are one of society's most vulnerable populations, children (Figley, 1995).

The capacity for caring that brings many social workers to the specialization of child welfare, in addition to daily interactions with young victims puts child welfare workers at risk of developing compassion fatigue (Anderson, 2000; Figley, 1995). According to Figley (1995), other professionals such as firefighters, police officers, and others in emergency response professions are at risk of developing compassion fatigue; however those who work with the trauma of children report higher incidence of compassion fatigue. Two factors associated with the incidence of social workers or therapists developing compassion fatigue are "empathy" and "exposure" (Figley, 1995, p. 15).

To date the literature tends to agree that compassion fatigue is the natural bi-product of working with traumatized individuals, as opposed to burnout which has been related to job stress (Figley, 2002; Maslach, 1982). Figley's (1995; 2002) work has conceptualized a relationship between the professional's empathy levels and the development of compassion fatigue. With this in mind, the researchers operationally defined compassion fatigue for the study as participant's inability to feel, and express empathy toward clients.

Scales for empathy and coping within an author created questionnaire were used to identify levels of compassion fatigue and coping among child welfare workers. It was thought that results of quantitative analysis would reveal a significant relationship between empathy and coping skills. A relationship between these two variables was expected to be valuable for child welfare agencies, due to the importance of preventing compassion fatigue among workers in direct service to clients.

In addition to being exposed to other's traumatic experiences, child welfare workers are confronted with the complexities of working within public agencies with legal mandates. Since the majority of child welfare clients are legally mandated to participate in services, clients typically are considered non-voluntary. Social workers can feel vulnerable working with non-voluntary clients if clients become hostile or defensive with workers regarding the custody of their children. Working with non-voluntary clients, vulnerable children, and a complex legal system can all contribute to the development of compassion fatigue among social workers (Drake & Yadama, 1996).

The involved nature of work within public child welfare made the coping skills of social workers an area of interest to the study. As was expected, a relationship

between compassion fatigue, which was defined as participant's levels of empathy, and coping was revealed. This was interpreted to indicate participants' ability to express and feel empathy was impacted by one's ability to cope. A significant relationship between these two variables not only provided support for the hypothesis, but also the work of other researchers that document the importance of coping to the prevention and management of compassion fatigue (Anderson, 2000; Figley, 1995, 2002; Regehr et al., 2004; Sabin-Farrell & Turpin, 2003).

The bi-county aspect of the study was used to assess similarities and differences between two Southern California Counties, San Bernardino and San Diego. Other variables important to the study were ethnicity, gender, workers' area of specialization, number of years in child welfare, number of years with current agency, hours worked per week, time off from work, and exposure to compassion fatigue training. Results of the study established a strong relationship between the number of years participants worked in child welfare and the number of years participants were employed with their current Counties. Overall, this relationship was thought to indicate workers are being maintained within their current

agencies. No significant difference was found between counties on this measure.

When analyzing the subscales identified within the instrument, significant relationships were found for the empathy subscales. A positive correlation was established for Responding with Empathy and Empathy toward Clients, meaning that one's ability to respond and express empathy is related. Lack of Empathic Feelings and Empathy toward Clients also had a significant positive relationship. This was interpreted to mean that as one's ability to feel empathy for clients increased, so did one's ability to express empathy toward clients. A negative relationship was identified; however for Responding with Empathy and Lack of Empathic Feelings. This result was thought to indicate that with low (increased absence) or lack of empathic feelings, the ability to respond with empathy decreases. Empathy toward Clients was also negatively correlated to the number of hours participants worked in a week, meaning that as number of hours increased, worker's ability to express empathy to clients decreased.

When comparing means, *t*-tests revealed a negative relation between the Exercise and Self-Care subscale and training for compassion fatigue. Those participants who had not received training for compassion fatigue were less

likely to use active coping strategies, such as exercise and self-care. This finding indicates the importance of training related to the health and well-being of those providing care to traumatized individuals. In their article regarding burnout among helping professionals, Spicuzza and De Voe (1982) recommend "exercise, hobbies, personal time, nutritional diet, development of relaxation skills, and summer vacations or weekend trips" (p. 96) as coping strategies to prevent or remedy burnout.

Additional *t*-tests revealed a significant difference for gender on measures of Responding with empathy. Mean scores for males (M = 13.44) were significantly lower than for females (M = 14.39). However, no differences for gender were identified for the other subscales on measurements of empathy.

Both counties were evaluated on the previously mentioned statistical measures and results from the two counties were compared and contrasted. Significant differences were between the means for the Empathy toward Clients subscale. San Diego had a significantly higher mean (M = 25.98) when compared to San Bernardino (M = 25.03). On all other statistical measures that compared bi-county data, no significant results were found. Due to the consistency among the counties, it is

thought that bi-county data obtained in this study will generalize to the broader population of child welfare workers in other counties.

Limitations

The instrument used in the study was an author created questionnaire that had not been used in prior studies. Although subscales were identified within the two major scales for empathy and coping, further testing is recommended to refine the subscales. Additionally, further analysis is recommended to determine if other subscales can be identified to make the questionnaire more comprehensive in scope.

Quantitative data were analyzed for the study. It is thought that the study would have benefited from the integration of qualitative data in the form of interviews. This type of data would have added a richness to the results by providing narrative descriptions of social workers experiences, and issues related to compassion fatigue. The use of qualitative data would have provided insight and clarified the direction of future research.

Recommendations for Social Work Practice, Policy and Research

A significant relationship was confirmed between compassion fatigue and the coping skills of child welfare workers. Due to the impact of these two variables on social worker well-being, it is vital that child welfare practice begin to take steps to prevent and treat this condition among social workers. As was suggested by the data, child welfare workers who are not receiving education and training in their agencies may especially be at risk for compassion fatigue.

Since social workers in child welfare often work in direct service to clients, specifically children, workers suffering from this condition may unintentionally put clients at risk of receiving lower quality service and intervention. In addition, social workers are often role models of behavior for clients. Maltreating parents often lack appropriate ways of coping that often are displayed in problems with anger management, poor quality parenting skills, and substance abuse. When social workers lack appropriate coping strategies to help themselves deal with the trauma of others, it is unlikely that they will provide the modeling that often occurs in healthy social worker/client relationships.

Results of the study indicate that agencies are maintaining child welfare workers within their agencies for longer than seven years (M = 7.86. SD = 5.40). While this was considered a positive outcome regarding social worker retention, it is important to recognize that Figley's (2002) study of Child Protective Services Workers found that workers with more time on the job experienced the symptoms of compassion fatigue to a greater extent than those with fewer years. In addition, Drake and Yadama's (1996) study of burnout and job exit among child welfare workers found that "emotional exhaustion had a direct effect on job exit" (p. 7). With this in mind, it is recommended that further research be conducted to evaluate the cumulative effects of trauma on child welfare workers who have been on the job longer.

The terrorist attack on September 11, 2001 raised awareness regarding compassion fatigue, when individuals assisting the injured, dying, and loved ones at Ground Zero reported being gravely impacted by the trauma of those they were in fact trying to help. In their discussion of the journey toward healing that was required of teachers affected by compassion fatigue related to the September 11th incident, Lantieri and Nambiar (2004) recount the analogy of emergency procedures on planes that

require individuals to first put their own oxygen masks on before assisting others. Insight was provided by the authors who developed Project Renewal, a program for over 2,000 New York teachers to assist them in healing from compassion fatigue post September 11th (Lantieri & Nambiar, 2004). The authors state, "We started to realize that the work we were doing in the aftermath of September 11th was work that needed to be done prior to such a crisis" (Lantieri & Nambiar, 2004, p. 121). The type of work presented in Lantieri and Nambiar's (2004) article refers to one-day and weekend retreats that emphasize a holistic approach to healing that includes stress management, self-care training, social support, and reflection exercises.

Professionals in trauma work, specifically child welfare must be trained to put on their oxygen masks prior to attempting to help someone else. It was thought that child welfare practice could learn from the experience of these teachers who became trauma workers in a crisis situation. Child welfare workers face on a daily basis traumas of similar magnitude, though unique to their profession. The researchers recommend a policy change to mandate compassion fatigue training. It was thought a mandate for training conducted by agencies would prepare

workers to take care of themselves, prior to the next crisis. With continued research and education into the interventions that work in relieving compassion fatigue, it is thought that programs similar to Project Renewal would develop as an outgrowth of increased training.

Conclusions

It was concluded that the hypothesis was supported by the data. Although social worker retention for the agencies was not problematic as first thought, further research was recommended regarding the topic to explore, expand, and clarify the subscales for empathy and coping in depth. Also qualitative data in the form of interviews with child welfare workers was recommended to guide future studies. It was suggested that the profession of child welfare learn from the September 11th attacks and the compassion fatigue that resulted for trauma workers, by taking a proactive approach to assist social workers in the management of this condition. Ultimately, compassion fatigue has been noted by Figley (1995, 2002, p. 11), as "a natural by-product of caring for traumatized people". With this in mind, it is imperative to social worker well-being and the best interests of clients that experts

in child welfare and agencies continue to explore this topic.

APPENDIX A

QUESTIONNAIRE

Questionnaire A

Please answer the following questions by circling the number that corresponds with the correct feeling:

Strongly Disagree Disagree Disagree Somewhat Agree Somewhat Agree Strongly agree

1. I feel as though the work I do in DCS makes a difference in the lives of parents and their children.

   1 2 3 4 5 6

2. I have few interests or hobbies outside of the work I do in DCS.

   1 2 3 4 5 6

3. It is important to me to seek out the support of colleagues, friends, and family when I am experiencing stress related to work in Children's Services.

   1 2 3 4 5 6

4. I am frustrated with client's excuses for not following case plans, and feel cynical about their ability to change.

   1 2 3 4 5 6

5. When I feel stressed-out from working with clients, I self-medicate with food, alcohol, or drugs.

   1 2 3 4 5 6

6. I am sensitive toward the families and children I serve at DCS, and am able to identify strengths in families that face many challenges.

   1 2 3 4 5 6

7. I do not feel comfortable sharing issues of counter transference in supervision.

   1 2 3 4 5 6

8. I am able to express empathy toward abusive parents, their children and families that I come into contact with as a DCS worker.

   1 2 3 4 5 6

9. I do not participate in any regular activity or exercise program during my off work hours.

   1 2 3 4 5 6

OVER

Strongly Disagree **Disagree** **Disagree Somewhat** **Agree Somewhat** **Agree** **Strongly agree**

10. I am too exhausted after work to exercise and would consider myself a "couch potato."

1 2 3 4 5 6

11. I can identify with the difficulties and challenges faced by DCS clients, and I express compassion and empathy toward them readily.

1 2 3 4 5 6

12. I have sought out therapy to help me deal with working with difficult clients and the exposure to vicarious trauma related to work in DCS.

1 2 3 4 5 6

13. When I am overwhelmed with stress related to work with DCS, I isolate myself from my peers.

1 2 3 4 5 6

14. I feel as though the work I do in DCS does not make a difference in people's lives.

1 2 3 4 5 6

15. I cope with the stress of exposure to other's traumatic experiences by seeking support in supervision.

1 2 3 4 5 6

16. I find support in my spiritual beliefs and/or religious affiliation that enables me to handle the difficult work associated with DCS.

1 2 3 4 5 6

17. I am easily irritated and frustrated by the clients I serve at DCS.

1 2 3 4 5 6

18. It is important for child welfare workers to identify and use a variety of healthy outlets for coping with stresses experienced on the job.

1 2 3 4 5 6

19. I use reflective listening when communicating with clients and respond to them empathically.

1 2 3 4 5 6

OVER

Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly agree

20. I have difficulty identifying strengths in the lives of DCS clients.

1 2 3 4 5 6

21. I am unable to find support among friends and family for the stress I experience working with maltreating parents, because of the negative perceptions surrounding DCS.

1 2 3 4 5 6

22. I feel energized when helping DCS clients, and strive to find the best ways to serve them.

1 2 3 4 5 6

23. I feel dispassionate about my work with DCS clients, because of the chronic nature of the problems associated with child abuse.

1 2 3 4 5 6

24. It is important to me to respond empathically toward clients and their situations.

1 2 3 4 5 6

25. I find that the stress associated with working in DCS is relieved by participation in hobbies and/or activities (examples: painting, scrap booking, writing/journaling, gardening, decorating, home improvement projects, etc...).

1 2 3 4 5 6

26. I have difficulty expressing or feeling empathy toward my DCS clients.

1 2 3 4 5 6

27. I find the support of colleagues helpful when dealing with the stress associated with working in DCS.

1 2 3 4 5 6

28. I do not seek out therapy or counseling for issues related to the work I do in DCS.

1 2 3 4 5 6

OVER

Strongly Disagree **Disagree** **Disagree Somewhat** **Agree Somewhat** **Agree** **Strongly agree**

29. I have identified positive self-care strategies (examples: getting regular exercise, prayer and/or meditation, massages and/or facials, healthy eating habits, yoga) in response to the stress experienced working in DCS.

1 2 3 4 5 6

30. I am numb to the issues surrounding child abuse and neglect and find it difficult to express compassion toward maltreating parents.

1 2 3 4 5 6

31. I feel and express care and concern for the families I serve at DCS.

1 2 3 4 5 6

32. I often feel overwhelmed by the problems and issues facing DCS clients.

1 2 3 4 5 6

33. I am emotionally moved by the circumstances faced by my clients and am able to respond empathically toward them.

1 2 3 4 5 6

34. I dread going to work at DCS and feel fatigued throughout the workday.

1 2 3 4 5 6

35. I participate in some kind of physical activity or exercise three or more times per week to relieve the stress associated with working with DCS clients.

1 2 3 4 5 6

36. I do not seek out supportive relationships with colleagues at DCS.

1 2 3 4 5 6

37. I tend to neglect self-care, due to the high demands related to working with DCS clients.

1 2 3 4 5 6

38. I find the support of friends and family helpful for dealing with the unique stresses of working in DCS.

1 2 3 4 5 6

OVER

Please answer the following demographic questions accordingly.

Gender: (Circle) Male Female

State Age at Last Birthday: _____

State Number of Years Employed in DCS: _____

State Number of Years with the County you are currently employed with: _____

Level of Education: (Circle)

BA MA MSW MFT LCSW DSW

Area of Specialization: (Circle)

Adoption/PP FR FM Intake/ER

State Job Title: _____

Annual Income: (Circle)

Under $35,000 $35,000-45,000 $45,000-55,000 $55,000-65,000 Over 65,000

Ethnicity: (Circle)

African American Caucasian Hispanic Asian Other: _____

State Average Number of Hours Worked in a Typical Week: _____

State the Number of Days-Off in the Last Year (Vacation): _____

The County has provided me with education and training regarding compassion fatigue and healthy coping strategies. (Circle) Yes No

Questionnaire B

Please answer the following questions by circling the number that corresponds with the correct feeling:

Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly agree

1. I feel as though the work I do in HHSA makes a difference in the lives of parents and their children.

   1 2 3 4 5 6

2. I have few interests or hobbies outside of the work I do in HHSA.

   1 2 3 4 5 6

3. It is important to me to seek out the support of colleagues, friends, and family when I am experiencing stress related to work in Children's Services.

   1 2 3 4 5 6

4. I am frustrated with client's excuses for not following case plans, and feel cynical about their ability to change.

   1 2 3 4 5 6

5. When I feel stressed-out from working with clients, I self-medicate with food, alcohol, or drugs.

   1 2 3 4 5 6

6. I am sensitive toward the families and children I serve at HHSA, and am able to identify strengths in families that face many challenges.

   1 2 3 4 5 6

7. I do not feel comfortable sharing issues of counter transference in supervision.

   1 2 3 4 5 6

8. I am able to express empathy toward abusive parents, their children and families that I come into contact with as a HHSA worker.

   1 2 3 4 5 6

9. I do not participate in any regular activity or exercise program during my off work hours.

   1 2 3 4 5 6

OVER

Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly agree

10. I am too exhausted after work to exercise and would consider myself a "couch potato."

1 2 3 4 5 6

11. I can identify with the difficulties and challenges faced by HHSA clients, and I express compassion and empathy toward them readily.

1 2 3 4 5 6

12. I have sought out therapy to help me deal with working with difficult clients and the exposure to vicarious trauma related to work in HHSA.

1 2 3 4 5 6

13. When I am overwhelmed with stress related to work with HHSA, I isolate myself from my peers.

1 2 3 4 5 6

14. I feel as though the work I do in HHSA does not make a difference in people's lives.

1 2 3 4 5 6

15. I cope with the stress of exposure to other's traumatic experiences by seeking support in supervision.

1 2 3 4 5 6

16. I find support in my spiritual beliefs and/or religious affiliation that enables me to handle the difficult work associated with HHSA.

1 2 3 4 5 6

17. I am easily irritated and frustrated by the clients I serve at HHSA.

1 2 3 4 5 6

18. It is important for child welfare workers to identify and use a variety of healthy outlets for coping with stresses experienced on the job.

1 2 3 4 5 6

Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly agree

19. I use reflective listening when communicating with clients and respond to them empathically.

1 2 3 4 5 6

20. I have difficulty identifying strengths in the lives of HHSA clients.

1 2 3 4 5 6

21. I am unable to find support among friends and family for the stress I experience working with maltreating parents, because of the negative perceptions surrounding HHSA.

1 2 3 4 5 6

22. I feel energized when helping HHSA clients, and strive to find the best ways to serve them.

1 2 3 4 5 6

23. I feel dispassionate about my work with HHSA clients, because of the chronic nature of the problems associated with child abuse.

1 2 3 4 5 6

24. It is important to me to respond empathically toward clients and their situations.

1 2 3 4 5 6

25. I find that the stress associated with working in HHSA is relieved by participation in hobbies and/or activities (examples: painting, scrap booking, writing/journaling, gardening, decorating, home improvement projects, etc…).

1 2 3 4 5 6

26. I have difficulty expressing or feeling empathy toward my HHSA clients.

1 2 3 4 5 6

27. I find the support of colleagues helpful when dealing with the stress associated with working in HHSA.

1 2 3 4 5 6

28. I do not seek out therapy or counseling for issues related to the work I do in HHSA.

1 2 3 4 5 6

OVER

Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly agree

29. I have identified positive self-care strategies (examples: getting regular exercise, prayer and/or meditation, massages and/or facials, healthy eating habits, yoga) in response to the stress experienced working in HHSA.

1 2 3 4 5 6

30. I am numb to the issues surrounding child abuse and neglect and find it difficult to express compassion toward maltreating parents.

1 2 3 4 5 6

31. I feel and express care and concern for the families I serve at HHSA.

1 2 3 4 5 6

32. I often feel overwhelmed by the problems and issues facing HHSA clients.

1 2 3 4 5 6

33. I am emotionally moved by the circumstances faced by my clients and am able to respond empathically toward them.

1 2 3 4 5 6

34. I dread going to work at HHSA and feel fatigued throughout the workday.

1 2 3 4 5 6

35. I participate in some kind of physical activity or exercise three or more times per week to relieve the stress associated with working with HHSA clients.

1 2 3 4 5 6

361. I do not seek out supportive relationships with colleagues at HHSA.

1 2 3 4 5 6

37. I tend to neglect self-care, due to the high demands related to working with HHSA clients.

1 2 3 4 5 6

38. I find the support of friends and family helpful for dealing with the unique stresses of working in HHSA.

1 2 3 4 5 6

Please answer the following demographic questions accordingly.

Gender: (Circle) Male Female

State Age at Last Birthday: _____

State Number of Years Employed in HHSA: _____

State Number of Years with the County you are currently employed with: _____

Level of Education: (Circle)

BA MA MSW MFT LCSW DSW

Area of Specialization: (Circle)

Adoption/PP FR FM Intake/ER

State Job Title: _____

Annual Income: (Circle)

Under $35,000 $35,000-45,000 $45,000-55,000 $55,000-65,000 Over 65,000

Ethnicity: (Circle)

African American Caucasian Hispanic Asian Other: _____

State Average Number of Hours Worked in a Typical Week: _____

State the Number of Days-Off in the Last Year (Vacation): _____

The County has provided me with education and training regarding compassion fatigue and healthy coping strategies. (Circle) Yes No

APPENDIX B

INFORMED CONSENT

A Bi-County Examination of Child Welfare Worker's Levels of Compassion Fatigue and Coping Skills

Informed Consent

You are invited to participate in a research study of child welfare workers from San Bernardino County and San Diego County. Levels of compassion fatigue and coping skills will be identified and compared between the two counties. Participation in the study is open to individuals' employed in San Bernardino or San Diego County with specialization in adoptions or permanency planning, family reunification, family maintenance, or emergency response/intake. We ask that you read this document and ask any questions you may have before agreeing to participate in the study. This study is being conducted by Pamela Marie Keyes and Christina Leigh Smith, graduate students in the Master of Social Work program at California State University San Bernardino, under the supervision of Dr. Rosemary McCaslin.

Procedure:
If you agree to participate in the present study, you will be asked to complete a 50 item questionnaire. A 6-point Likert scale will be used to evaluate levels of compassion fatigue and coping skills. Demographic data will also be collected. It is anticipated that the questionnaire will take approximately 25 minutes to complete.

Risks and Benefits:
No foreseeable risks or benefits to participants are expected.

Voluntary Nature of the Study:
Participation in this study is voluntary. Your decision whether or not to participate will not affect your relationship with California State University San Bernardino, or your relationship with your employer. If you decide to participate, you are free to not answer any question or withdraw at any time with out affecting those relationships.

Confidentiality:
Participation in the study is confidential. Participants will not be asked to provide their name or any other identifying information on the questionnaire.

Compensation:
Participants may take part in a raffle for four $25 dollar gift certificates good at either the Claim Jumper Restaurant or Target. In order to participate in the raffle, participant's desk phone number must be written on the back of the Ticket, and returned to the researchers in the envelope provided. Participation is voluntary and participants may withdraw from the study at any time without penalty. You do not have to complete the questionnaire to participate in the raffle.

Contact Information:
Please contact Dr. Rosemary McCaslin at (909) 880-5507 with any questions or concerns you may have regarding your participation in the study. For the protection of participants, the research has been approved by the Department of Social Work Subcommittee of the Institutional Review Board at California Sate University, San Bernardino.

Statement of Consent:
Please mark the appropriate statement with an X and the date.

I consent to participate in the study _____ **Date:** _____

I do not consent to participate in the study _____ **Date:** _____

APPENDIX C

DEBRIEFING STATEMENT

A Bi-County Examination of Child Welfare Workers' Levels of Compassion Fatigue and Coping Skills

Debriefing Statement

You have just completed a questionnaire designed to evaluate levels of compassion fatigue and coping skills among child welfare workers in San Bernardino County and San Diego County. Compassion fatigue has been defined by the researchers as the reduced capacity of social workers to respond empathically toward clients. It is believed by the researchers that the ways that workers cope with the stresses associated with work in child protection will impact levels of compassion fatigue. No deception was used in formulating the questionnaire, and participants are not expected to experience any negative effects from participation in the study. Due to the confidential nature of the study no individual results will be available; however overall results and findings of the study are expected to be available at the John M. Pfau Library, California State University San Bernardino by October, 2005.

The study is being conducted as a Master of Social Work research project at California State University San Bernardino by Pamela Marie Keyes and Christina Leigh Smith, under the supervision of Dr. Rosemary McCaslin, Department of Social Work. Any questions or concerns regarding your participation in the study should be directed to Dr. McCaslin.

Dr. Rosemary McCaslin, Department of Social Work
California State University San Bernardino
5500 University Parkway
San Bernardino, CA 92407-2397
(909) 880-5507

Thank you for your participation.

APPENDIX D

ROTATED COMPONENT MATRICES FOR SUBSCALES

EMPATHY AND COPING

Rotated Component Matrix(a)

	Component			
	1	2	3	4
e12	.738	-.331	.205	-.220
e13	.727	-.136	.344	.074
e9	.667	.035	.424	-.185
e4	-.644	.375	.058	.212
e14	-.623	.504	-.090	.161
e3	-.555	.413	-.122	.411
e5	-.471	.394	.303	.006
e11	-.270	.770	-.104	.008
e15	-.199	.756	-.176	.014
e8	-.103	.682	-.230	.277
e7	.209	-.159	.824	-.044
e2	-.001	-.232	.717	-.097
e10	.443	-.032	.599	-.191
e6	.171	.015	.044	-.818
e1	-.086	.200	-.158	.777

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.
a Rotation converged in 17 iterations.

Rotated Component Matrix(a)

	Component						
	1	2	3	4	5	6	7
c20	-.843	.057	.047	.032	-.038	-.002	-.075
c5	.801	.010	-.052	-.039	-.030	.062	.271
c6	.761	-.064	.072	-.048	-.061	.331	-.182
c17	-.616	.455	.133	-.004	.155	.058	-.085
c22	.510	-.145	.072	-.317	-.030	.303	.062
c10	-.107	.738	.030	-.174	.048	.064	.208
c13	.099	.624	.050	.257	-.119	-.373	-.067
c11	-.191	.599	-.045	.023	.285	-.129	-.258
c12	.048	-.449	.351	-.422	-.007	.153	-.020
c7	.016	.037	.890	.001	.049	-.053	-.016
c16	.147	-.041	-.836	-.079	-.070	.022	-.158
c9	.018	-.032	.164	.760	.164	-.054	.140
c21	.140	-.070	.162	-.528	-.013	-.068	.486
c23	-.298	.508	.118	.512	.185	.018	-.134
c8	.270	-.018	.319	-.336	-.149	.280	.008
c2	.094	.074	.085	.302	.717	.119	-.117
c3	.031	-.066	.362	.200	-.634	.259	-.293
c14	-.137	.334	.169	.023	.602	-.092	-.096
c15	-.202	-.170	.056	.465	.577	.081	-.154
c18	.094	-.035	-.001	.029	-.015	.793	-.012
c19	.223	-.151	-.023	-.047	.001	.727	.117
c1	.190	-.044	.098	.088	-.087	.112	.799
c4	-.159	.185	-.252	-.116	-.264	.321	.327

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.
a Rotation converged in 12 iterations.

APPENDIX E

KEY FOR ROTATED COMPONENT MATRICES

Key For Rotated Component Matrices

Empathy Scale (e)	Coping scale (c)
Question 1 = e1	Question 2 = c1
Question 4 = e2	Question 3 = c2
Question 6 = e3	Question 5 = c3
Question 8 = e4	Question 7 = c4
Question 11 = e5	Question 9 = c5
Question 14 = e6	Question 10 = c6
Question 17 = e7	Question 12 = c7
Question 19 = e8	Question 13 = c8
Question 20 = e9	Question 15 = c9
Question 23 = e10	Question 16 = c10
Question 24 = e11	Question 18 = c11
Question 26 = e12	Question 21 = c12
Question 30 = e13	Question 22 = c13
Question 31 = e14	Question 25 = c14
Question 33 = e15	Question 27 = c15
	Question 28 = c16
	Question 29 = c17
	Question 32 = c18
	Question 34 = c19
	Question 35 = c20
	Question 36 = c21
	Question 37 = c22
	Question 38 = c23

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ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

   Assigned Leader: Pamela Keyes

   Assisted By: Christina Smith

2. Author Created Questionnaire:

   Assigned Leader: Pamela Keyes

   Assisted By: Christina Smith

3. Data Entry and Analysis:

   Team Effort: Pamela Keyes & Christina Smith

4. Writing Report and Presentation of Findings:

   a. Introduction

      Assigned Leader: Christina Smith

      Assisted By: Pamela Keyes

   b. Literature Review, Methods, and Results

      Assigned Leader: Pamela Keyes

      Assisted By: Christina Smith

   c. Discussion

      Assigned Leader: Pamela Keyes

      Assisted By: Christina Smith